

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0054890</u></p> <p>Facility Name: <u>St. Clara's Rehab and Senior Care</u></p> <p>Address: <u>1450 Castle Manor Drive</u> <u>Lincoln</u> <u>62656</u> Number City Zip Code</p> <p>County: <u>Logan</u></p> <p>Telephone Number: <u>217-735-1507</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/13/18</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David M Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP/CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David M Underwood</u>			(Title) <u>EVP/CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) () _____ Fax # () _____																																									

Facility Name & ID Number St. Clara's Rehab and Senior Care

0054890 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 2/13/18

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	106	40,152	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	106	40,152	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,357	9,993	2,023	28,373	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,357	9,993	2,023	28,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.66%

D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 2/13/18

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 106 and days of care provided 2,023

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	249,993	15,634	8,379	274,006		274,006		274,006		1
2	Food Purchase		186,624		186,624		186,624		186,624		2
3	Housekeeping	94,905	30,359		125,264		125,264		125,264		3
4	Laundry	70,409	22,515		92,924		92,924		92,924		4
5	Heat and Other Utilities			139,765	139,765		139,765		139,765		5
6	Maintenance	86,779	38,294	125,556	250,629		250,629		250,629		6
7	Other (specify):*										7
8	TOTAL General Services	502,086	293,426	273,700	1,069,212		1,069,212		1,069,212		8
	B. Health Care and Programs										
9	Medical Director			27,162	27,162		27,162		27,162		9
10	Nursing and Medical Records	2,154,127	155,947	455,648	2,765,722		2,765,722		2,765,722		10
10a	Therapy		210,690	40,908	251,598	(251,442)	156		156		10a
11	Activities	60,622	3,361		63,983		63,983		63,983		11
12	Social Services	45,847		3,691	49,538		49,538		49,538		12
13	CNA Training	4,944	1,247		6,191		6,191		6,191		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,265,540	371,245	527,409	3,164,194	(251,442)	2,912,752		2,912,752		16
	C. General Administration										
17	Administrative	90,900			90,900		90,900		90,900		17
18	Directors Fees										18
19	Professional Services			307,214	307,214		307,214	(7,671)	299,543		19
20	Dues, Fees, Subscriptions & Promotions			284,747	284,747	(215,978)	68,769	(50,654)	18,115		20
21	Clerical & General Office Expenses	217,769	13,601	25,247	256,617		256,617		256,617		21
22	Employee Benefits & Payroll Taxes			715,512	715,512		715,512		715,512		22
23	Inservice Training & Education			3,049	3,049		3,049		3,049		23
24	Travel and Seminar			9,097	9,097		9,097	(4,098)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,282	96,282		96,282		96,282		26
27	Other (specify):* Lost Items-Residents			3,649	3,649		3,649	(1,500)	2,149		27
28	TOTAL General Administration	308,669	13,601	1,444,797	1,767,067	(215,978)	1,551,089	(63,923)	1,487,166		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,076,295	678,272	2,245,906	6,000,473	(467,420)	5,533,053	(63,923)	5,469,130		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							569,349	569,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			667	667		667	426,153	426,820			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			643,925	643,925		643,925	(643,925)				34
35	Rent-Equipment & Vehicles			32,313	32,313		32,313		32,313			35
36	Other (specify):*											36
37	TOTAL Ownership			676,905	676,905		676,905	351,577	1,028,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			545,806	545,806	251,442	797,248		797,248			39
40	Barber and Beauty Shops			10,060	10,060		10,060		10,060			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					215,978	215,978		215,978			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			555,866	555,866	467,420	1,023,286		1,023,286			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,076,295	678,272	3,478,677	7,233,244		7,233,244	287,654	7,520,898			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number St. Clara's Rehab and Senior Care

0054890

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,741)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,098)			19
20	Contributions	(1,500)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,671)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50,654)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,664)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	354,318		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 354,318		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 287,654		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

St. Clara's Rehab and Senior Care

ID# 0054890

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22		0	30	22
23		(7,671)	19	23
24		(1,500)	27	24
25		(50,654)	20	25
26		(4,098)	24	26
27		0	6	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(63,923)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Clara's Rehab and Senior Care# 0054890

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,671)	0	0	0	0	0	0	0	0	0	0	(7,671)	19
20	Fees, Subscriptions & Promotions	(50,654)	0	0	0	0	0	0	0	0	0	0	(50,654)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,098)	0	0	0	0	0	0	0	0	0	0	(4,098)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	27
28	TOTAL General Administration	(63,923)	0	0	0	0	0	0	0	0	0	0	(63,923)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,923)	0	0	0	0	0	0	0	0	0	0	(63,923)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Clara's Rehab and Senior Care# 0054890

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	569,349	0	0	0	0	0	0	0	0	0	569,349	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,741)	428,894	0	0	0	0	0	0	0	0	0	426,153	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(643,925)	0	0	0	0	0	0	0	0	0	(643,925)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,741)	354,318	0	351,577	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,664)	354,318	0	287,654	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors List Attached				St Clara's Senior Servi	Lincoln	Sponsor Org
(Not for profit Board-No individual ownership)				Castle Manor	Lincoln	Supportive Living

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$					1
2	V	34 Adjustment for Related Organization	643,925				(643,925)	2
3	V			St Clara's Senior Services Inc.	100.00%			3
4	V	30		St Clara's Senior Services Inc.		569,349	569,349	4
5	V	32		St Clara's Senior Services Inc.		428,894	428,894	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 643,925			\$ 998,243	\$ * 354,318	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Board Members are not compensated								\$	1
2	for their services									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Clara's Rehab and Senior Care

0054890

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Heartland Bank & Trust		x	Mortgage			\$	\$		\$ 428,894	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Heartland Bank & Trust									667	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 429,561	9									
B. Non-Facility Related*																				
10	Interest Income									(2,741)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (2,741)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 426,820	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Clara's Rehab and Senior Care COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0054890

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,507 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
St. Clara's Senior Services - Owns real and personal property.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>2007</u>	<u>\$ 247,441</u>	1
2					2
3	TOTALS			\$ 247,441	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	106			2018	\$ 18,474,934	\$ 385,752		\$ 385,752	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35	Depreciation									
36										

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St. Clara's Rehab and Senior Care

0054890

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 18,474,934	\$ 385,752		\$ 385,752	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,307	\$ 178,922	\$ 178,922	\$		\$	71
72	Current Year Purchases	1,679,972						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,682,279	\$ 178,922	\$ 178,922	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2015 Grand Caravan	2015	\$ 32,723	\$ 4,675	\$ 4,675	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 32,723	\$ 4,675	\$ 4,675	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 20,437,377	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 569,349	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 569,349	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: St. Clara's Senior Services

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>2018</u>	<u>106</u>		\$ <u>643,925</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>106</u>		\$ <u>643,925</u>			7

10. Effective dates of current rental agreement:

Beginning 2/2018

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2019</u>	\$ <u>680,736</u>
13.	<u>/2020</u>	\$ <u>680,736</u>
14.	<u>/2021</u>	\$ <u>680,736</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 32,313 Description: Copiers and televisions

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,247		1,247
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,944		4,944
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,191	\$	\$ 6,191
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,191		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Cost		4 Outside Practitioner (other than consultant)		5 Supplies (Actual or Allocated)	6 Total Units (Column 2 + 4)	7 Total Cost (Col. 3 + 5 + 6)	8	
			Units of Service		Units	Cost							
1	Licensed Occupational Therapist		hrs	\$			\$	226,085	\$		\$	226,085	1
2	Licensed Speech and Language Development Therapist		hrs					90,553				90,553	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist		hrs					229,168	156			229,324	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy		# of prescripts						210,534			210,534	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify):							40,908				40,908	13
14	TOTAL			\$			\$	586,714	\$	210,690	\$	797,404	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St. Clara's Rehab and Senior Care

0054890

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 269,477	\$	1
2	Cash-Patient Deposits	39,523		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	733,451		3
4	Supply Inventory (priced at <u>FIFO</u>)	42,948		4
5	Short-Term Investments			5
6	Prepaid Insurance	23,110		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(404,345)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 704,164	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 704,164	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,162,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,523		28
29	Short-Term Notes Payable	60,000		29
30	Accrued Salaries Payable	240,299		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,312		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	37		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Bed Tax</u>	14,210		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,556,498	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,556,498	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (852,334)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 704,164	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 478,490	1
2	Restatements (describe):		2
3	Rounding error	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 478,487	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,330,821)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,330,821)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (852,334)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,412,140	1
2	Discounts and Allowances for all Levels	(1,789,942)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,622,198	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,879,409	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,879,409	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,331	12
13	Barber and Beauty Care	11,357	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378,371	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	671	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 391,730	23
D. Non-Operating Revenue			
24	Contributions	6,345	24
25	Interest and Other Investment Income***	2,741	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,086	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,902,423	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,069,212	31
32	Health Care	3,164,194	32
33	General Administration	1,767,067	33
B. Capital Expense			
34	Ownership	676,905	34
C. Ancillary Expense			
35	Special Cost Centers	555,866	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,233,244	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,330,821)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,330,821)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **St. Clara's Rehab and Senior Care**

0054890

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,838	1,955	\$ 72,567	\$ 37.12	1
2	Assistant Director of Nursing	1,822	1,938	61,133	31.54	2
3	Registered Nurses	8,126	8,645	280,486	32.44	3
4	Licensed Practical Nurses	20,536	21,847	585,388	26.79	4
5	CNAs & Orderlies	62,003	65,961	1,094,694	16.60	5
6	CNA Trainees	555	591	4,944	8.37	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,890	2,011	59,859	29.77	8
9	Activity Director					9
10	Activity Assistants	4,721	5,023	60,622	12.07	10
11	Social Service Workers	1,782	1,896	45,847	24.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,866	23,262	249,993	10.75	15
16	Dishwashers					16
17	Maintenance Workers	4,718	5,019	86,779	17.29	17
18	Housekeepers	9,257	9,848	94,905	9.64	18
19	Laundry	6,034	6,419	70,409	10.97	19
20	Administrator	1,955	2,080	90,900	43.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,083	9,663	217,769	22.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,186	166,158	\$ 3,076,295 *	\$ 18.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$ 8,379	35
36	Medical Director	27,162	36
37	Medical Records Consultant	1,916	37
38	Nurse Consultant		38
39	Pharmacist Consultant	5,093	39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant	3,691	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 46,241	49

C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$ 94,555	50
51	Licensed Practical Nurses	208,763	51
52	Certified Nurse Assistants/Aides	145,321	52
53	TOTAL (lines 50 - 52)	\$ 448,639	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Gail McGinnis</u>			\$ <u>90,900</u>	<u>Workers' Compensation Insurance</u>	\$ <u>61,496</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>7,235</u>	<u>Advertising: Employee Recruitment</u>	<u>4,210</u>	
				<u>FICA Taxes</u>	<u>235,337</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>371,974</u>	<u>(Indicate # of checks performed)</u>	<u>3,515</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>PR</u>	<u>16,139</u>	
				<u>Other Benefits</u>	<u>39,470</u>	<u>Dues & Subscriptions</u>	<u>5,665</u>	
						<u>License & Fees</u>	<u>8,280</u>	
						<u>Less: Public Relations Expense</u>	<u>(16,139)</u>	
						<u>Non-allowable advertising</u>	<u>(3,555)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>90,900</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>715,512</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>18,115</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ <u>0</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
								<u>8,880</u>
								<u>11</u>
							<u>Seminar Expense</u>	<u>206</u>
								<u>(4,098)</u>
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>4,999</u>
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Heritage Operations Group</u>	<u>Management</u>		\$ <u>288,793</u>					
<u>JM Abbott</u>	<u>Audit</u>		<u>8,500</u>					
<u>Principal Financial</u>	<u>401 k consulting</u>		<u>2,250</u>					
<u>Legal adj to Zero</u>			<u>7,671</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>307,214</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Clara's Rehab and Senior Care# 0054890

Report Period Beginning:

1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of Illinois
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 215,978
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 934
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Y
Firm Name: JM Abbott
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

**St. Clara's Rehab and Senior Care
2018 Cost Report
Supplemental Schedules
Reclassification Entries**

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 210,534
Purchased Hospital Services	14,495
Purchased Laboratory Services	16,591
Purchased Radiology Services	9,822
Amount Reclassified to Line 39	<u>\$ 251,442</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (60,228)
Provider Assesment Fee - \$6.07	<u>(155,750)</u>
	<u>(215,978)</u>
Provider Participation Fee	<u>215,978</u>

St. Clara's Manor Inc.
HFS ID# 376075710001
HFS Cost Report - December 31, 2018
Board of Directors

<u>Member</u>	<u>Home City</u>	<u>State</u>
Clyde Reynolds - President	Lincoln	IL
Dr. Dennis Carroll - Vice President	Lincoln	IL
Tonita Reifsteck - Sec./Treas.	Lincoln	IL